Clark Plastic & Hand Surgery

4510 Medical Center Drive, Suite 305
McKinney, TX 75069

221 W Colorado Boulevard, Suite 943
Dallas, TX 75208

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Sex: ☐ M ☐F	Marital status (circle one) Single / Mar / Div / Wid

Former Name if Applicable:	Preferred Contact Number:	Social Security No.:	Race:	Birth date: / /	Age:

Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Email Address:	PCP:

Preferred Method of Contact: ☐ Home/Cell Phone ☐Work Phone ☐Mail to my home ☐ Mail to my work ☐Email ☐ Patient Portal

Verbal Communication: ☐ You may leave a message with callback number only ☐You may leave a message with detailed information

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr.: _____ ❑ Insurance Plan ❑ Hospital/ER

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other _____

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I hereby assign to Clark Plastic and Hand Surgery any insurance benefits available for healthcare services provided to me. I understand that Clark Plastic and Hand Surgery has the right to refuse or accept assignment of such benefits. I understand that I am financially responsible for any balance. I also authorize Clark Plastic and Hand Surgery or any of its employees or agents to release any information required for treatment, healthcare operations and processing claims.

Patient/Guardian signature *Date*

Clark
Plastic
&
Hand
Surgery

OFFICE POLICIES

Please take a moment to review our office policies.

Appointments

- Our office hours are Monday, Tuesday and Thursday from 9:00 am - 5:00 pm, Wednesday from 9:00 am -7:00 pm and Friday from 9:00 am - 3:00 pm, closed for lunch daily from 12:00 pm-1:00 pm.
- Missed appointments, appointment cancellation and surgical cancellation are costs to CPHS. If you are unable to keep your appointment, please provide 24-hour notice.
- For repeated "No-Shows," and cancellations within 24 hours of scheduled appointment, CPHS reserves the right to discontinue care of the patient.

Payment Options

1. Cash
2. Personal Check
3. Visa, MasterCard, Discover and American Express
4. CARECREDIT: Offers patients a line of credit to cover you or your family's health care needs. In most situations, this is an interest free program for up to 6 months. Please inquire with office staff to attain further information regarding the different programs we offer.

Financial and Insurance Policies

- The patient is responsible for all deductibles and coinsurances as well as any estimated fee that their insurance carrier does not cover. All payments for services are expected at the time of visit, including self-pay fees, co-payments, deductibles, and previous balances.
- ***CPHS does not bill third parties for services rendered.***
- Insurance cards from the patient or policy holder are required with every appointment.
- We will file your claim with insurance at no charge and will make every effort to assure you receive maximum benefits. In order to provide this service, we will need your updated insurance information **before** each appointment.
    - It is the patient's responsibility to keep us updated with correct, current insurance information and any address changes.
- If your insurance requires a referral, advanced notice is needed (3-5 days). Referral must be in hand before scheduled appointment or the appointment will be rescheduled.
- A claim must be established and written authorization of approval is required before any services can be rendered for worker's compensation claims.
- In the event of denials, errors, service caps, policy exclusions, or non-covered services the patient is responsible for payment of all services rendered. **Please Initial** _____

Surgical Procedures and Deposits

- The surgical booking fee is required to schedule surgical procedures. The remaining fees will be due two weeks prior to surgery.
- Deposits for surgeries cancelled earlier than two weeks prior to surgical date will be refunded the full amount. Deposits for surgeries cancelled under two weeks prior to surgical date will not be refunded.
- CPHS reserves the right to asses a $100 fee for surgeries canceled within one business day of scheduled date for any reason (including failure of nicotine testing).
- CPHS reserves the right to asses a $100 fee for surgeries rescheduled more than 2 times for non-medical related reasons.
- **Notice of Physician Financial Ownership:** Dr. Clark holds financial interest and/or ownership in McKinney Surgery Center. We are required by 42 C.F.R. § 416.50 to disclose this financial interest and/or ownership in writing and in advance of the date of scheduled procedure. If you do not wish to have your procedure done at this facility please notify staff.

Collections Policy

- I hereby give express permission to CPHS and all CPHS business associates to call my cell phone (_____) for collection of past due monies on my account.
  Please Initial _____
- If collection services are required to obtain payment, I understand and agree that I will be responsible for an addition 35% of the total balance in addition to the actual balance that passes 90 days past due that is discharged to the collections agency. I also understand that all discounts applied to my balance will be reversed upon my account being discharged to the collections agency. **Please Initial** _____

Other Charges

- There is a $35 fee for all returned checks.
- There is $20 fee for transferring medical records for the first 25 pages and an additional $0.25 per page for every page thereafter. There is a $5 fee for radiology images provided on a CD.
- There is a $35 fee for completion of disability, employer related or legal forms.

After Hours/Emergencies

- In an emergency, call 911 or go directly to the nearest Emergency Room.
- Urgent matters after hours, please call Dr. Clark's pager: 972-229-1048.

Thank you for your reading and understanding our policy form.

_____ _____ _____

Signature of Patient/Responsible Party Relationship (if applicable) Date

Clark
Plastic
&
Hand
Surgery

Reason for today's visit:	
Date symptoms began:	Is this visit related to an injury? Y N
If so please describe how injured:	
Height:	**Weight:**

Review of Systems

Please select all that currently apply

☐ Unintentional Weight Loss	☐ Night Sweats	☐ Fever or Chills	☐ Chest Pain
☐ Bloody Sputum	☐ Persistent Cough	☐ Problems with Bleeding	☐ Problems with Scarring
☐ Rash	☐ Problems with Healing	☐ Depression	☐ Anxiety
☐ Anorexia	☐ Muscle Weakness	☐ Season Allergies	☐ Sore Throat
☐ Blurry Vision	☐ Nausea/Vomiting	☐ Abdominal Pain	

PAST MEDICAL HISTORY

Select any of the following medical conditions that you currently have

☐ Adrenal Insufficiency	☐ Anemia/Thalassemia	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Atrial Fibrillation (Irregular Heartbeat)
☐ Auto-Immune Disease	☐ Bipolar Disorder	☐ Blood Clotting Difficulties
☐ BPH	☐ Breast Cancer	☐ COPD
☐ Coronary Artery Disease	☐ Crohn's Disease	☐ Deep Venous Thrombosis
☐ Depression	☐ Diabetes	☐ Dyspnea
☐ Easy Bruising	☐ End Stage Renal Disease	☐ GERD
☐ Generalized Weakness	☐ Head Trauma	☐ Hearing Loss
☐ Hepatitis	☐ Hypertension	☐ HIV / AIDS
☐ Hypercholesterolemia	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Lupus	☐ Migraines	☐ Neuropathy
☐ Paralysis	☐ Petechie	☐ Pneumothorax
☐ Poor wound healing	☐ Pulmonary Embolism	☐ Renal Disorder
☐ Rheumatoid Arthritis	☐ Seizures	☐ Severe Reaction to Anesthesia
☐ Stroke	☐ Trauma	☐ Ulcerative Colitis
☐ Vision Loss	☐ None	☐ Other _____

PAST SURGERIES/COSMETIC PROCEDURES

List all past surgical procedures

Clark
Plastic
&
Hand
Surgery

SKIN DISEASE HISTORY (For Reconstructive Surgery Patients Only) Have you had any of the following skin conditions?	BREAST CANCER (For Breast Reconstructive Patients Only) Do you have a family history of cancer?
☐ Basal Cell Skin Cancer ☐ Blistering Sunburns ☐ Squamous cell skin cancer ☐ None ☐ Other _____	☐ Yes ☐ No If so, which relative: _____

Pharmacy (Please provide name, phone number and nearest intersection)	
Name:	Address:
Phone:	Fax:

Medications/Supplements (All prescription and over the counter medications)

Name	Dosage	Directions

Allergies
List all allergies and reactions if known:

Social History

Smoking Status (please choose one):	Number of Cigarettes/Packs Per Day:
☐ Current everyday smoker ☐ Current someday smoker ☐ Former smoker ☐ Never smoker ☐ Smoker current status unknown ☐ Unknown if ever smoked	Total Years Smoking: When Did You Quit Smoking: Alcohol Intake: ☐ None ☐ 1 or less per day ☐ 1-2 per day ☐ 3 or more drinks per day
Occupation/Workplace:	
Place of Residence:	

Steven Clark, MD, PLLC
Notice of Privacy Practices

Effective Date: August 1, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact: HIPAA Privacy Officer at 469-675-3659.

This Notice describes how physicians engaged in the private practice of medicine at STEVEN CLARK, MD, PLLC facilities (collectively all such physicians are referred to as "Practitioners") may use and disclose your protected health information for purposes of treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. It also describes your rights to access and control your protected health information.

A record of care and services is created in order to manage the care you receive and to comply with certain legal requirements. The Practitioners understand that medical information about you is personal. The Practitioners are committed to protecting medical information about you. The Practitioners are required by law to:

- maintain the privacy of your protected health information;
- provide you with this notice summarizing the Practitioners legal duties and practices related to the use and disclosure of medical information;
- abide by the terms of the notice currently in effect;
- notify affected individuals following a breach of unsecured Protected Health Information.

The Practitioners may dispose of your medical records ten (10) years after the date of your last visit to an STEVEN CLARK, MD, PLLC facility, or after applicable periods specified in existing law.

The Practitioners reserve the right to change this notice. The new notice will be effective for all protected health information that the Practitioners possess at that time and that the Practitioners receive in the future. The current notice will be available upon request at STEVEN CLARK, MD, PLLC facilities.

1. Protected Health Information – Uses and Disclosures

The following categories describe the types of uses and disclosures of your Protected Health care Information that the Practitioners, their office staff, and their agents may make once you have acknowledged receipt of this notice. For each category of uses or disclosure this notice will explain what is meant and provide some examples. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made as allowed under the law.

Treatment, Including Continuity Of Care: The Practitioners will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your Protected Health Information. For example the Practitioners would disclose your protected health information, as necessary, to a home health agency that provides care to you. The Practitioners will also disclose protected health information to other physicians who may be treating you when you have given the necessary permission to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, the Practitioners may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: The Practitioners may use and disclose medical information about you so that the treatment and services you receive or are provided on your behalf by the Practitioners covered by this Notice may be billed to and payment may be collected from you, an insurance company or a third party. For example, the Practitioners may need to give your health plan information about services you received so your health plan will pay the involved Practitioners or reimburse you for the service. The Practitioners may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. You have the right to request that any disclosures to your health plan made for purposes of receiving payment or to otherwise facilitate healthcare operations be restricted where payment for the service or item at issue has been remitted in full by a person or entity other than the health plan.

Healthcare Operations. The Practitioners may use or disclose, as needed, your protected health information in order to support the business activities of their practices. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, the Practitioners may disclose your protected health information to their office staff to coordinate your care and records. In addition, the Practitioners may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. The Practitioners may also call you by name in the waiting room when your physician is ready to see you.

Appointment Reminders. The Practitioners may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Treatment Alternatives and Health-Related Benefits and Services. The Practitioner may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact your Practitioner's office from where you received such material to request, in writing, that these materials not be sent to you.

Fundraising Activities. A Practitioner may use or disclose your demographic information and the dates that you received treatment from your Practitioner, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact your Practitioner's office, in writing, and request that these fundraising materials not be sent to you.

Facility Directories: Unless you sign a document to become a "No Information Patient," the Practitioners may use and disclose in a directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

Individuals Involved in Your Care or Payment for Your Care. The Practitioners may release medical information about you to a friend or family member who is involved in your medical care. The Practitioners may also give information to someone who helps pay for your care. The Practitioners may also tell your family or friends your condition and that you are in the hospital. In addition, the Practitioners may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Emergencies. The Practitioners may use or disclose your protected health information in an emergency treatment situation without your acknowledgment of this Notice. If this happens, an attempt will be made to try and obtain your acknowledgement as soon as reasonably practicable after the delivery of treatment. If a Practitioner is required by law to treat you and the Practitioner has attempted to obtain your acknowledgment but is unable to obtain your acknowledgment, he or she may still use or disclose your protected health information for treatment, payment and operation purposes.

Research. The Practitioner may use or disclose information about you for purposes of research projects approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. The Practitioner will almost always ask for your specific permission if they will have access to your name, address or other information that reveals who you are, or will be involved in your care.

Food and Drug Administration. The Practitioner may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required

As Required By Law. The Practitioners will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety.. The Practitioners may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor the Practitioners may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Practitioners may release medical information about you as required by military command authorities. The Practitioners may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation The Practitioners may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Participation in Health Information Exchange. The Practitioners, affiliated hospitals, and/or other healthcare professionals that provide treatment services to STEVEN CLARK, MD, PLLC patients may participate in a Health Information Exchange ("HIE"). An HIE allows participating providers secure, immediate electronic access to your pertinent protected health information maintained by participating health care providers as necessary as necessary for treatment. You have the option to "opt-out" of participation in the HIE, precluding your providers from sharing your health information for purposes of treatment. If you have not opted out of the HIE, your protected health information will be available through the HIE to participating health care providers that have a treatment relationship with you, consistent with this Notice of Privacy Practices and the law. If you opt-out of participation in the HIE, your protected health information will not be available through the HIE for your treating providers to search and locate in conjunction with your treatment, but will otherwise continue to be used consistent with this Notice of Privacy Practices and the law. For more information about opting out of the HIE, or for rejoining the HIE subsequent to a previous decision to opt out, you may visit www.ntahp.org,

Public Health Risks. The Practitioners may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;

- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Practitioners may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Practitioners may disclose medical information about you in response to a court or administrative order. The Practitioners may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement. The Practitioners may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct in the clinic; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Practitioners may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Practitioners may also release medical information about patients to funeral directors as necessary to carry out their duties.
National Security and Intelligence Activities. The Practitioners may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Protective Services for the President and Others. The Practitioners may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Practitioners may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
Required Uses and Disclosures: Under the law, the Practitioners must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.
Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing, except to the extent that a Practitioner or his or her practice has taken an action in reliance on the use or disclosure indicated in the authorization. Examples of the types of uses and disclosures that require a written authorization include: uses or disclosures of psychotherapy notes not subject to specific exceptions defined within applicable regulations; uses and disclosures of Protected Health Information to be used for marketing, unless communication is made face to face or is for a promotional gift of nominal value; uses and disclosures of Protected Information that is a sale of such information as defined within applicable regulations

2. Your Health Information Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
Right to inspect and/or obtain a written or electronic copy of your protected health information. You have the right to inspect and/or obtain a copy of your medical information, as provided by law. Usually this includes medical and billing records but does not include psychotherapy notes. You must submit your request to inspect and/or obtain a copy of your health information in writing to the STEVEN CLARK, MD, PLLC facility at which you were treated. Your request to inspect and/or obtain a copy may be denied in certain circumstances and in case of such denial, you may have the right to have this decision reviewed by a health care professional of the Practitioner's choosing. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the facility at which the Practitioner provided you care.
Right to have your physician amend your protected health information. If you feel medical information the Practitioner have about you is incorrect or incomplete, you may request that the information be amended. You must submit a request for amendment to the STEVEN CLARK, MD, PLLC facility at which you were treated with a reason supporting your request to amend. The request may be denied if the request is;

- Not in writing
- not supported or corroborated
- to amend information that is accurate or complete
- to amend parts of the information you are not permitted to inspect or copy, by law
- to amend part of the record which is not maintained or was not created by the Practitioner.

For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the STEVEN CLARK, MD, PLLC facility at which the Practitioner provided you care.
Right to request a restriction of your protected health information. You may ask a Practitioner not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care, unless provided for by law. The Practitioners are not required by law to agree to a restriction that you may request, unless the request is to restrict a disclosure to a health plan for purposes of payment or operations that relates to a service or item for which you or a source other than the health plan has already remitted payment in full. You may request a restriction by completing a Request for Restrictions form and present it to a registration representative at the STEVEN CLARK, MD, PLLC facility at which you were treated for acceptance or denial. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the STEVEN CLARK, MD, PLLC facility at which the Practitioner provided you care.
Right to request confidential communications. You have the right to request that the Practitioner communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that you only be contacted at work or by mail. Please make this request in writing to a registration representative at the STEVEN CLARK, MD, PLLC facility at which you were treated. You will not be asked the reason for your request, and reasonable requests will be accommodated. Your request may also be conditioned on you providing information as to how payment will be handled or specification of an alternative address or other method of contact. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to communications of or with the STEVEN CLARK, MD, PLLC facility at which the Practitioner provided you care.
Right to an accounting of disclosures, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or other allowed disclosures including those to family members or friends involved in your care, as described in this Notice of Privacy Practices. It may also exclude disclosures made based upon a written authorization from you. You have the right to a list of disclosures for time periods no longer than six years and not before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists you may be charged a fee which you will be asked for prior to compiling the list. Please make any requests for a list of disclosures covered by this Notice to the STEVEN CLARK, MD, PLLC facility where you were treated, in writing. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to disclosures made by the STEVEN CLARK, MD, PLLC facility at which the Practitioner provided you care.
Right to obtain a paper copy of this notice . Upon request, the Practitioner office will provide you with a paper copy of this notice, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to a Practitioner, to the STEVEN CLARK, MD, PLLC facility were the Practitioner provided you care, or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the Practitioner. You may file a complaint with the Practitioner by notifying your Practitioner or with the facility by notifying STEVEN CLARK, MD, PLLC, HIPAA Privacy Officer, 4510 Medical Center Drive, Suite 305 McKinney, TX 75069, of your complaint. All complaints must be in writing, and you will not be retaliated against for filing a complaint.
You may contact our Privacy Officer at 469-675-3659.
This notice was published and becomes effective on August 1, 2015..

Clark Plastic & Hand Surgery

4510 Medical Center Drive, Suite 305
McKinney, TX 75069

221 W Colorado Boulevard, Suite 943
Dallas, TX 7208

ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

By signing this form, you agree that you have received our Notice of Privacy Practices. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations. This applies to the privacy practices of Clark Plastic & Hand Surgery (CPHS) and all affiliated covered entities of CPHS issuing this Notice.

You have the right to review our Notice of Privacy Practices prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested or call our office at (469) 675-3659.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that CPHS and all affiliated covered entities can use and disclose your protected health information in accordance with HIPAA.

_____ _____ _____

PATIENT FULL NAME PATIENT SIGNATURE DATE

_____ _____

RESPONSIBLE PARTY FULL NAME RESPONSIBLE PARTY SIGNATURE

_____ _____

RELATIONSHIP DATE

For Office Use Only

We attempted to attain written acknowledgment of our Receipt of Privacy Notice, but the acknowledgment could not be met due to the following reason/s: (check all that apply)

- ○ Patient/Responsible Party did not want to Date: _____
- ○ Communication barriers forbid us to obtain the acknowledgment
- ○ An emergency situation prohibit us to get acknowledgement
- ○ Other (Please Specify)

_____

_____